Seek specificity in heart failure documentation to better reflect patient severity, ensure accurate coding

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by Leatrice Ford, RN, BSN, CCS

If your facility has seen a huge decrease in cardiovascular (CV) reimbursement since the implementation of MS-DRGs, don't panic—just yet. There are several reasons why cardiac case mix index has decreased in hospitals nationwide.

One devastating blow was the movement to cost-based payments. The cardiac community did not fare well in defending the high costs of their programs, but that's a topic for an entirely separate article. Between 2006 and 2008, the Centers for Medicare & Medicaid Services (CMS) reduced the CV MS-DRG payments by $1 billion nationally for Major Diagnostic Category (MDC) 5. The most common reasons why CV revenue suffered under MS-DRGs include the following:

- The deletion of major CV conditions created in 2006 and the exclusion of the principal diagnosis in the severity logic
- The deletion of many CV diagnoses as complications/comorbidities (CC)
- The stratification of CCs into two separate categories—CCs and major CCs (MCC)

The majority of the CV MS-DRGs, especially the procedures, require an MCC to move cases to the higher-weighted MS-DRG of the pair.

Although the CC and MCC list includes more than 4,200 diagnoses, many of them are rarely applicable or coded. CMS published a CC analysis file in the 2008 IPPS final rule that shows the distribution of coded diagnoses using 2006 Medicare data. The analysis file showed only 2,251 of the CC/MCC diagnoses were coded more than 10 times. View the table below for the top CC/MCC diagnoses coded in 2006, according to the 2008 IPPS final rule.

Code	Description	# patients with diagnosis coded	% of total patients with diagnosis	CC/MCC
599.0	Urinary tract infection, site not specified	1,239,727	11%	CC
403.91	Hypertensive renal disease, unspecified benign or malignant, with mention of renal failure	830,347	7%	CC
276.1	Hyposmolality and/or hyponatremia	600,335	5%	CC
584.9	Acute renal failure, unspecified	523,620	4%	MCC
486	Pneumonia, organism unspecified	516,411	4%	MCC
425.4	Primary cardiomyopathies	462,435	4%	CC
491.21	Obstructive chronic bronchitis with acute exacerbation	371,923	3%	CC
285.1	Acute posthemorrhagic anemia	366,571	3%	CC
518.81	Acute respiratory failure	347,323	3%	MCC
411.1	Intermediate coronary syndrome (unstable angina)	308,777	3%	CC
263.9	Unspecified protein-calorie malnutrition	301,271	3%	CC
518.0	Pulmonary collapse (atelectasis)	251,607	2%	CC
511.9	Unspecified pleural effusion	241,316	2%	CC
276.2	Acidosis	201,605	2%	CC

Source: Centers for Medicare & Medicaid Services

Coders and clinical documentation specialists might be tempted to focus on these diagnoses when working with their physicians to improve documentation for severity of illness. It's a good start, but don't overlook the diagnoses that used to be CCs under DRGs and that need more specific documentation to be a CC/MCC under MS-DRGs.

The most important of these conditions is congestive heart failure (CHF), unspecified (code 428.0). Remember that CMS deleted code 428.0 along with another heart failure code (428.9 for heart failure, unspecified), as CC/MCCs under MS-DRGs. Unfortunately, in 2006 providers reported these codes for 94% of the 2.4 million Medicare patients with heart failure. Providers reported "acute" heart failure for less than 1% of patients with heart failure despite the fact that cardiac patients frequently present with acute heart failure even when it is not the principal diagnosis. Only "acute" heart failure is considered an MCC.

Most hospitals have prioritized education and querying for better specificity of heart failure, but they may not completely realize the potential financial effects of their efforts.

ConsultCare Partners, LLC performed a coding analysis for a facility that discharges approximately 2,852 Medicare cardiac patients annually. The analysis showed that

59% of its admissions included code 428.0, CHF. Seven percent of admissions (i.e., 210 admissions) included CHF as a secondary diagnosis but no other CCs or MCCs. If the physicians had documented that the heart failure was "acute," the additional reimbursement would be more than $1 million annually. The table below illustrates the potential reimbursement for this facility according to MS-DRG:

Original MS-DRG with code 428.0 as a secondary diagnosis	**Cases**	**Additional reimbursement**
227 Cardiac defibrillator implant w/o cardiac cath w/o MCC	18	$163,674
220 Cardiac valve & other major cardiothoracic procedure w/o cardiac cath w/ CC	9	$131,319
287 Circulatory disorders except AMI, w/ cardiac cath w/o MCC	23	$113,490
310 Cardiac arrhythmia & conduction disorders w/o CC/MCC	29	$107,987
234 Coronary bypass w/ cardiac cath w/o MCC	11	$85,145
247 Percutaneous CV procedure w/ drug-eluting stent w/o MCC	11	$68,681
243 Permanent cardiac pacemaker implant w/ CC	11	$62,003
249 Percutaneous CV procedure w/ non-drug-eluting stent w/o MCC	9	$55,575
309 Cardiac arrhythmia & conduction disorders w/ CC	23	$55,530
244 Permanent cardiac pacemaker implant w/o CC/MCC	6	$53,964
281 Acute myocardial infarction, discharged alive w/ CC	14	$51,462
238 Major CV procedures w/o MCC	6	$41,658
253 Other vascular procedures w/ CC	11	$38,987
218 Cardiac valve & other major cardiothoracic procedure w/ cardiac cath w/o CC/MCC	2	$37,152
236 Coronary bypass w/o cardiac cath w/o MCC	5	$33,629
251 Percutaneous CV procedure w/o coronary artery stent or AMI w/o MCC	5	$33,080
225 Cardiac defibrillator implant w/ cardiac cath w/o AMI/HF/shock w/o MCC	3	$32,619
240 Amputation for circulatory system disorders except upper limb & toe w/ CC	3	$29,208
221 Cardiac valve & other major cardiothoracic procedure w/o cardiac cath w/o CC/MCC	2	$28,986
217 Cardiac valve & other major cardiothoracic procedure w/ cardiac cath w/ CC	2	$24,678
241 Amputation for circulatory system disorders except upper limb & toe w/o CC/MCC	2	$23,310
254 Other vascular procedures w/o CC/MCC	3	$22,458
232 Coronary bypass w/ PTCA w/o MCC	2	$16,812
285 Acute myocardial infarction, expired w/o CC/MCC	2	$8,795
282 Acute myocardia infarction, discharged alive w/o CC/MCC	6	$8,513
TOTAL ANNUAL	**210**	**$1,328,711**

Source: Leatrice Ford, RN, BSN, CCS of ConsultCare Partners, LLC

The hospital was able to use this breakdown of MS-DRG data to direct coders and clinical documentation specialists to focus on obtaining more specificity in heart failure diagnoses. Because the physicians already documented the heart failure, coders and clinical documentation specialists needed only to educate them regarding naming the specific type of heart failure (e.g., systolic or diastolic) and whether it was acute, chronic, or acute on chronic.

Address this through physician group education and follow up with individual physician contact. It's always helpful to use data to determine which physicians are documenting heart failure as secondary so you can target those high-volume physicians first.

Note that this analysis was only for MDC5 CV patients. Because heart failure is common among Medicare patients, there are significant opportunities to obtain better specificity. Team up with clinicians to collect and disseminate core measures information to obtain the most accurate picture of just how widespread heart failure is among your Medicare patients.

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Interested in learning more about heart failure coding? ***Robert S. Gold, MD,*** *and* ***Shannon McCall, RHIA, CCS, CPC-I,*** *will discuss this topic during an upcoming HCPro audio conference, "Heart Failure Coding: Accurate Assignment to Reflect Patient Severity" on April 9.*